MDR: M4-02-1978-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for dates of service 01/22/01 through 03/01/01.
   b. The request was received on 02/06/02.

II. EXHIBITS

1. Requestor, Exhibit I:
   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. HCFAs
   c. TWCC-62 forms
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:
   a. TWCC 60 and Position Statement located on the TWCC-60 form
   b. EOBs
   c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 06/03/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 06/10/02. The response from the insurance carrier was received in the Division on 06/21/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Additional Information submitted by Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 05/24/02
   "The services provided are for chronic pain management, CPT Code 97799-CPAP. The TWCC Fee Guidelines do not set a fee for CPT 97799-CPAP, but state that they to be paid DOP or dependent on the procedures documented. (Provider's) position is that the fee paid for these services by the carrier were not 'fair and reasonable'."

2. Respondent: TWCC 60 Statement
"Please refer to the attached documents responsive to this request."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are 02/07/01 through 03/01/01. Dates of service 01/22/01 through 02/05/01 are out of jurisdiction because the initial request for medical dispute packet was received by the Medical Review Division on 02/06/02.

2. Listed on the initial Table of Disputed Services, $1,400.00 was billed for date of service 02/14/01. However, a conflict exists between the billed amount on the Table and the HCFA and TWCC-62 form found in the provider's dispute packet. The HCFA shows that $1,225.00 was billed and the TWCC-62 dated 07/13/01 indicates the correct billed amount of $1,225 and a payment of $560.00 with the outstanding balance of $665.00.

3. The revised amount billed is $21,000.00; the revised amount paid is $16,380.00; the revised amount in dispute is $4,620.00.

4. The carrier denied the billed services by code, "F – Reduced According to Fee Guideline" and "*N – Not Documented; N, 205 – THIS CHARGE WAS DISALLOWED AS ADDITIONAL INFORMATION/DEFINITION IS REQUIRED TO CLARIFY SERVICE(S)/SUPPLY(IES) RENDERED."

5. The provider billed $175.00 per hour for CPT code 97799-CPAP, a DOP procedure, for the dates in dispute.

V. RATIONALE

Medical Review Division's rationale:

The Medical Fee Guideline Medicine Ground Rule (II) (G) (9) states, "Chronic Pain Management shall be billed as code 97799-CP…" Medical documentation indicates the services were rendered. Rule 134.304 (c) states, "At the time an insurance carrier makes payment or denies payment on a medical bill, the insurance carrier shall send, in the form and manner prescribed by the Commission, the explanation of benefits to the appropriate parties. The explanation of benefits shall include the correct payment exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s)…" The carrier failed to submit explanation of benefits which included the correct payment exception codes required by the Commission's instructions. It also failed to provide the provider with sufficient explanation to allow the provider to understand the reason for the denial.

Because CPT code 97799-CPAP has no MAR value, the carrier failed to provide sufficient explanation of benefits to the provider. The carrier failed to meet the standards set forth in Rule 134.304 (c), therefore, reimbursement in the amount of **$4,620.00** is recommended.

The above Findings and Decision are hereby issued this 7th day of February 2003.

Donna M. Myers
Medical Dispute Resolution Officer
Medical Review Division
DMM/dmm

V. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit $4,620.00 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 7th day of February 2003.

Carolyn Ollar
Medical Dispute Resolution Officer
Medical Review Division

DM/dmm